

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Patients With Cervical Cancer

TO THE EDITOR: The article by Chu and co-workers¹ in the July issue reports on quality of care in women with stage I cervical cancer (invasive and noninvasive). The authors report but do not comment upon the lack of difference in outcome whether the patients received their pre-conceived optimum or less than optimum care. Their study would be greatly enhanced by knowing what forms of so-called nonoptimum care resulted in no increase in death rate or recurrence of the disease. Perhaps unknowingly they may have discovered a more cost effective method of treating patients with cervical cancer.

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REFERENCE

1. Chu J, Polissar L, Tamimi HK: Quality of care in women with stage I cervical cancer. *West J Med* 1982 Jul; 137:13-17

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Drs. Chu and Tamimi Respond

TO THE EDITOR: In response to Dr. Kornfield's letter, we would like to comment on three points.

First, the lack of difference in the survival between optimal and suboptimal care groups was addressed in the "Comment" section of the paper:

The lack of difference in the three-year survival rates between the optimal and suboptimal care groups in stage IA cervical cancer is not surprising because most of the patients classified as suboptimal underwent simple hysterectomy for suspected carcinoma in situ and were diagnosed as having microinvasive cervical cancer from the pathologic specimen. So, even though patients did not have an optimal diagnosis, they did finally receive the standard definitive treatment. There was also no significant difference in survival rates between the optimal and suboptimal groups in stage IB. This lack of difference was probably due either to the short follow-up time or the possible efficacy of radiation immediately after simple hysterectomy, or both.^{10,11}

It should be noted that 22 women with stage IB cervical cancer in the suboptimal group received simple hysterectomy followed by radiation.

Second, although we did classify the women into optimal and suboptimal care groups, the

criteria used for classification were not "ours." The criteria used were those recognized to be the "standard of care" by most experts in the field.

Third, our study is not designed to evaluate efficacy of different types of therapies for stage I cervical cancer, but rather to explore the different characteristics of patients, hospitals and doctors. Selection bias as well as other problems precludes the comparison of the survival rates to measure efficacy of treatment.

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Radiology and Medical Care Costs

TO THE EDITOR: This is in regard to the August 1982 article "The Costs and Risks of Medical Care."¹ As a practicing general radiologist, I have seen tremendous changes in diagnostic imaging over the past five years. I have a full-time job keeping up with the changes. There is now a tremendous overlap of diagnostic imaging available for certain disease states; for example, surgical versus medical jaundice, evaluation of pancreatic size, and the use of hypertensive pyelograms. Physicians order tests in a manner that was present in the medical training of 1960. That is, the attending physician orders hypertensive intravenous pyelograms, oral cholecystography or other studies. I am sure that if there was consultation between practicing physicians and the radiologists before the tests were ordered, the number of tests would decrease and the yield of information would increase. It has been suggested that a consulting radiologist in a department to plan the type of tests for diagnostic problems would decrease the costs of medical care. The high cost of imaging and the significant difference in yield